Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ricky England a prisoner at HMP Wymott on 19 May 2018

A report by the Prisons and Probation Ombudsman

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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Ricky England died on 19 May 2018 at HMP Wymott. His cause of death has not yet been ascertained and will be decided at the Coroner's inquest. Mr England was found to have used a psychoactive substance (PS) before his death. He was 25 years old. I offer my condolences to his family and friends.

Although Mr England had long-term mental health problems, the mental health team never added him to their caseload. Instead, prison staff focused on punishing his poor behaviour.

When prison staff found him under the influence of PS, they did not manage him in line with their local drug strategy. I am concerned that illicit substances were readily available to Mr England, and that individual prisons are being left to develop local strategies to reduce the supply and demand for drugs. As I have previously recommended to the Chief Executive of HM Prisons and Probation Service, there is an urgent need for national guidance on how best to combat this serious problem. We have also written to the Prisons Minister to set out our concerns at the number of drug-related deaths in custody.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Sue McAllister CB
Prisons and Probation Ombudsman **June 2019**

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Summary

Events

1. Mr Ricky England was first sent to prison in 2010 when he was 17 years old. He was diagnosed with a learning disability, he had a strategy in place to assist him and it was advised that the justice and healthcare systems dealing with him should be made aware. Mr England subsequently spent a number of further periods in prison but the information about his learning disability was never referred to.

2. In April 2017, Mr England was sentenced to four years and eight months in prison for burglary. On 16 November 2017, he was moved to HMP Wymott. At his reception health screen, nurses noted that he had a history of mental health problems, including psychosis and personality disorder. A mental health nurse completed a review three months after he arrived in prison. Mr England had no care plans or medication reviews and did not receive ongoing support for his mental health problems.

3. Mr England was found under the influence of psychoactive substances (PS) six times but was not managed in line with the prison's local drug strategy. Each time, he was demoted under the Incentives and Earned Privileges (IEP) scheme but he never had a joint meeting with a substance misuse worker and a prison manager and never attended a workshop to address the dangers of PS use.

4. At 4.00pm on 19 May, an officer unlocked Mr England's cell door, found him unresponsive and radioed for healthcare staff to attend. However, as soon as staff realised that he was not breathing, they called a medical emergency code promptly. Prison and healthcare staff arrived and started cardiopulmonary resuscitation (CPR). Paramedics arrived at 4.26pm and at 5.03pm, pronounced that Mr England had died.

5. Toxicology tests found that Mr England had used olanzapine (which had been prescribed to him) and PS in the hours before his death.

Findings

6. The clinical reviewer found that overall, Mr England's substance misuse and mental health care was not equivalent to that which he could have expected to receive in the community. The manager of the integrated mental health team and the prison manager for reducing reoffending have since outlined plans to improve substance misuse and mental health services, and introduced some new procedures.

8. Wymott has a substance misuse strategy, with distinct processes for managing prisoners suspected of or testing positive for PS. Staff only partially complied with procedures when Mr England was suspected under the influence of PS. After each episode, they monitored him and downgraded him under the incentives and earned privileges scheme, but did not follow the other prescribed steps. The substance misuse team did not offer Mr England access to potentially beneficial courses. It is clear that more needs to be done to limit the supply and demand for drugs. There is now an urgent need for Her Majesty's Prison and

Probation Service (HMPPS) to issue national guidance on this, rather than leaving prisons to develop their own local strategies on a piecemeal basis. The Chief Executive of HMPPS agreed to issue a national drug strategy by the autumn of 2018. We are concerned that at the time of writing (January 2019), this has not yet materialised.

9. When staff found Mr England collapsed, a defibrillator was unusable because one of the shock pads were missing. A second one was found and used promptly but this may not be the case in another emergency.

10. The healthcare staff who attended the emergency response did not feel supported after the incident.

Recommendations

- The Head of Healthcare and the manager of the integrated mental health team should ensure that prisoners with mental health issues have appropriate reviews and care plans which are recorded and implemented.
- The Chief Executive of HMPPS should provide the Ombudsman with a revised date for issuing detailed national guidance on measures to reduce the supply and demand of drugs in prisons, and an assurance that this new date will be met.
- The Governor should ensure that prisoners suspected of using psychoactive substances, or other illicit substances, are managed in line with the local drug strategy.
- The Governor and Head of Healthcare should ensure that all emergency response equipment is in good working order, including that staff regularly check defibrillators and replace any missing pads promptly.
- The Head of Healthcare should ensure that healthcare staff are appropriately supported after the death of a prisoner, in line with national instructions.

The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Wymott informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

12. The investigator visited Wymott on 29 May 2018. She obtained copies of relevant extracts from Mr England's prison and medical records.

13. The investigator interviewed one member of staff on the telephone on 16 August and interviewed 10 members of staff at Wymott on 21 August.

14. NHS England commissioned a clinical reviewer to review Mr England's clinical care at the prison. She conducted joint interviews with the investigator on 21 August.

15. We informed HM Coroner for Lancashire and Blackburn with Darwen of the investigation. We suspended our investigation from 7 June 2018 to 5 September 2018 when we received the results of Mr England's toxicology tests. We have sent the Coroner a copy of this report.

16. The investigator contacted Mr England's brother to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He did not respond.

17. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out a factual inaccuracy and this report has been amended accordingly.

Background Information

HMP Wymott

18. HMP Wymott is a medium security prison which holds over 1,100 adult men. Bridgewater Community NHS Trust and Greater Manchester Mental Health Trust provide healthcare services and Bridgewater Community NHS Trust also provides GP services. The local out-of-hours provider is responsible for the GP cover out of hours.

HM Inspectorate of Prisons (HMIP)

19. The most recent inspection of Wymott was in October 2016. Inspectors reported that the substance misuse strategy had improved, with effective communication and links between the safer prisons, security, offender management and drug strategy teams. They noted that security and drug strategy meetings were well attended and detailed information sharing took place between relevant departments.

20. Prisoners told HMIP that drugs were freely available. In their inspection survey, 63% of respondents said that it was easy to obtain illicit drugs, which was higher than at comparable prisons (43%). They noted that prisoners and staff were aware of the dangers of PS and had said that it was available on the wings. Inspectors found that a supply reduction strategy and a specific action plan were in place to reduce the use of PS, monitored by a well-attended drug strategy committee. Inspectors also found that drug testing after suspected use was too low, as testing staff were unavailable but this had increased in line with requests from prison staff.

21. Inspectors found that all new arrivals were screened for substance misuse problems and about two thirds of prisoners had received support for drug and alcohol problems. They noted that details in security information reports, prisoners' records and police reports were used to inform interventions. They found that there was a broad mix of individual and group support activities, as well as good peer support. They noted that dedicated nurses and visiting specialist substance misuse consultants assisted the drug services team and treatment regimes were flexible and reviewed regularly. They found that relationships between the psychosocial and clinical teams were excellent.

Independent Monitoring Board

22. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to May 2018, the IMB reported that the standard of healthcare was poor and frequently fell below that which could be expected in the community. The IMB also noted that increased bullying and debt had led to violence. They noted that use of psychoactive substances (PS) had resulted in injuries to prisoners and a high number of requests for ambulances, but improved strategies for dealing with such incidents had reduced the number of calls for ambulances towards the end of the reporting year.

Previous deaths at HMP Wymott

23. Mr England's was the seventeenth death at HMP Wymott since the beginning of 2016. There are similarities between Mr England's case and a death at the prison from illicit substances in July 2017. We made recommendations about the need to improve the local drug strategy and to offer support to prisoners.

24. There have been four further deaths since Mr England died which are under investigation. One of those deaths occurred in September 2018 and indicated illicit drug use.

PS

25. PS (formerly known as 'new psychoactive substances' or 'legal highs') are a serious problem across the prison estate. They are difficult to detect and can affect people in a number of ways, including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health, with links to suicide or self-harm.

26. In July 2015, we published a Learning Lessons Bulletin about the use of PS (still at that time NPS) and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of PS, the need for more effective drug supply reduction strategies, better monitoring by drug treatment services and effective violence reduction strategies.

27. HM Prison and Probation Service (HMPPS) now has in place provisions that enable prisoners to be tested for specified non-controlled PS as part of established mandatory drugs testing arrangements.

Incentives and Earned Privileges Scheme (IEP)

28. Each prison has an incentives and earned privileges (IEP) scheme which aims to encourage and reward responsible behaviour, encourage sentenced prisoners to engage in activities designed to reduce the risk of re-offending and to help create a disciplined and safer environment for prisoners and staff. Under the scheme, prisoners can earn additional privileges such as extra visits, more time out of cell, the ability to earn more money in prison jobs and wear their own clothes. There are four levels, entry, basic, standard and enhanced.

Key Events

29. Mr Ricky England had previous convictions and had been in prison several times. In 2010, Mr England was at HMPYOI Hindley. His prison records note concerns that he had a communication impairment. He was diagnosed with a language and communication impairment disorder. It was noted that he had literacy difficulties for which he needed support, and that language should be simplified to help him understand. It was noted that this strategy should be shared with prison staff, youth workers, social workers and solicitors.

30. In 2011, Mr England sustained a head injury in a car crash. Prison records show that he had some neuro-rehabilitation but it was not clear if this had also affected his language and communication as he was disengaged.

31. On 18 April 2017, Mr England was convicted of burglary and sentenced to four years and eight months in prison. He was sent to HMP Forest Bank.

32. On 16 November, Mr England was moved to HMP Wymott. A nurse completed his first reception health screen and noted that Mr England did not have any special educational needs. A nurse completed his second reception screen on 19 November. He noted that Mr England had had a head injury in 2011 and had previously had a gastric ulcer. Mr England told staff that he took medication for his mental health problems which included psychosis and personality disorder.

33. On 21 November, a nurse referred Mr England to the mental health team and on 28 November, a prison GP prescribed him antipsychotic medication and medication to prevent recurring ulcers.

34. An intelligence report submitted on 6 December indicated that there was a strong smell of cannabis from Mr England's cell. There was no reference to this event in his medical or personal record or that any action was taken.

2018

35. On 5 January 2018, staff suspected that Mr England was under the influence of PS. A nurse examined him and confirmed this. She advised wing staff to monitor him. Staff reduced his IEP level to basic for seven days.

36. On 10 January, Mr England was again found under the influence of PS. Staff placed him on the basic IEP regime for seven days.

37. An intelligence report submitted on 30 January indicated that Mr England was involved with selling "illicit goods". (The report provides no further information.) This was not recorded in his personal record and there is no record of any action taken.

38. On 11 February, staff again suspected that Mr England was under the influence of PS. Healthcare staff checked his observations and confirmed this. Staff placed him on the basic IEP regime for seven days.

39. On 13 February, Mr England was suspected of being under the influence of PS. He slurred his speech but denied taking any illicit substances. He refused to let a nurse examine him so she booked an appointment for 7 March for a GP to

review his suspected use of PS and his medication. Mr England never attended the appointment.

40. On 15 February, Mr England met a mental health nurse. He told her that he had mental health problems and had used drugs since he was 12 years old. He confirmed that he used PS. The nurse concluded that Mr England needed to see the mental health team. However, the team manager for integrated mental health and substance misuse, told the investigator that newly arrived prisoners with stable mental health problems remained under the care of the prison GP. (This is what happened with Mr England.) The team manager said that this policy is currently under review as the mental health team did not consider that this was the best approach and hoped to develop a new plan.

41. On 19 February, a substance misuse worker visited Mr England to offer him support after the suspected incident of PS use. He told her that he did not have a problem and did not want to work with the substance misuse team.

42. An intelligence report in April noted that Mr England had made an external telephone call to ask for "illicit items" to be brought in to him. During a targeted strip search on 30 April, two tablets fell out of his buttocks.

43. On 21 April, Mr England received news that his mother had died in hospital. He had a mental care meeting with a nurse and told her that he was trying not to use PS and he had spoken to his family. He said that he hoped to attend his mother's funeral on 1 May. However, days before the funeral, he smashed his cell door observation panel and the toilet and sink in his cell, and threatened staff. Staff moved him to the Care and Separation Unit (CSU, also referred to as the segregation unit), downgraded his IEP level to basic for 28 days and told him that he would not be allowed to attend the funeral. The record noted that during the controlled move, he sustained a cut to his head. On the day of his mother's funeral, he smashed the cell in the CSU and threatened to stab staff.

44. During a disciplinary hearing on 2 May, Mr England was again under the influence of PS. A nurse examined him and confirmed that he was under the influence so the hearing was adjourned.

45. Mr England was again found under the influence of PS on 14 May. He refused healthcare intervention. Staff placed him on the basic IEP regime for seven days and scheduled another appointment with the substance misuse team in line with Wymott's drug strategy. (Mr England died before the meeting took place.)

Events of 19 May

46. Mr England's cell was on the third floor of E wing. On the morning of 19 May, there had been three incidents on the same wing where prisoners had been found in their cells suspected of being under the influence of PS. Officers had called healthcare staff to check the prisoners and each prisoner was placed on the basic IEP regime.

47. At 12.15pm, as an officer was locking prisoners into their cells for lunch, he found Mr England in another cell (on the same landing) and escorted him to his cell. He told us that there were no issues to report.

48. At 4.00pm, the officer unlocked Mr England's door for him to collect his medication. He looked through the observation hatch but at first, he could not see him so he unlocked the cell door. He saw Mr England at the back of the cell, on his knees with his head on the floor. Mr England was unresponsive and in the same position as two of the prisoners who had been found that morning. The officer used his radio to call for healthcare assistance as he said that he suspected that Mr England was under the influence of PS. He also shouted to another officer to come to the cell to help him. Seconds later, both officers went into the cell and saw Mr England's face was blue. A prisoner went into the cell and asked what was happening. Both officers and the prisoner lifted Mr England onto his bed. The officer radioed a medical emergency code blue (to indicate breathing difficulties).

49. A nurse and a healthcare support worker, were administering medication on the wing when they heard the code blue over the radio. They locked up the medications and made their way to Mr England's cell. The healthcare support worker told us that she had brought the emergency bag and saw that Mr England was blue in colour on the bed. They asked for Mr England to be moved to the floor. The nurse began chest compressions and the healthcare support worker attached an airway as they began CPR. In the meantime, staff handed a defibrillator to the nurses but it did not have any pads so they asked for a second defibrillator which was promptly found and used. Officers carried Mr England to the landing outside the cell for more room. A prison manager, and another officer arrived and helped with resuscitation efforts. The defibrillator did not detect a shockable rhythm.

50. Paramedics arrived at 4.26pm and took over resuscitation attempts but they were unsuccessful and at 5.03pm, they declared that Mr England had died.

Contact with Mr England's family

51. The Governor and a family liaison officer (FLO), visited Mr England's family home and broke the news of Mr England's death to his family. They offered support and explained what would happen next.

52. Mr England's brother was his nominated next of kin. The prison held a memorial service on 31 May. Mr England's brother and a family friend attended.

53. In line with national instructions, the prison contributed to the costs of the funeral, which was held on 5 June.

Support for prisoners and staff

54. After Mr England's death, a prison manager debriefed the prison staff involved in the emergency response to ensure that they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

55. The nurse and the healthcare support worker said that they had not received support from their managers but their colleagues had been supportive.

56. The prison posted notices informing other prisoners of Mr England's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr England's death.

Digital autopsy radiology report

57. A consultant radiologist, completed a digital autopsy radiology report on 23 May. He did not provide a cause of death but noted no suspicious findings or abnormalities in any of the major organs (although there was a laceration on the side of Mr England's head). He noted that, in view of Mr England's clinical history, it was possible that he had taken a fatal drug overdose.

Toxicology report

58. The toxicology report found that Mr England had used a synthetic cannabinoid (a PS) in the hours before death. Toxicological analysis of Mr England's blood also found the presence of olanzapine (his prescribed antipsychotic medication).

59. The report noted that synthetic cannabinoids such as the type found in Mr England's blood had severe toxic effects, including rapid loss of consciousness, cardiopulmonary arrest (heart attack) and death.

60. The Coroner's officer told the investigator that the cause of Mr England's death would be decided at the inquest.

Findings

Clinical care

61. The clinical reviewer said that Mr England's primary care was equivalent to that which he could have expected to receive in the community. However, some aspects of his mental health care and substance misuse were not equivalent.

62. The clinical reviewer raised concerns about the lack of entries in the medical record and a lack of information in the 72-hour serious incident review, which the Head of Healthcare will need to address.

Mental healthcare

63. Mr England had mental health needs. The clinical reviewer said that significant information about his learning disability had been outlined in 2010 in his medical record. However, the historic information became buried in his records with the passage of time. We are concerned that there was no method for flagging up learning difficulties in a medical record. The clinical reviewer said that it was regrettable that screening for a learning disability was not incorporated into the reception and transfer screening process, and recommended that the healthcare commissioners addressed this. This is not within the remit of this investigation as it requires consultation and input from the health and justice systems (the police and court services). However, we agree that the commissioners will need to consider the recommendation.

64. The clinical reviewer said that although Mr England had a diagnosed mental illness and was prescribed antipsychotic medication, his mental health and medication compliance were not regularly reviewed, and there was no documented mental healthcare plan. We recommend that:

    The Head of Healthcare and the manager of the integrated mental health team should ensure that prisoners with mental health issues have appropriate reviews and care plans which are recorded and implemented.

PS at HMP Wymott

65. Wymott's substance misuse strategy was published in October 2016 and outlined a number of measures to reduce the demand and supply of illicit drugs. It said any prisoner found to be under the influence of illicit substances or involved in their supply and distribution should be placed on the basic IEP level for 28 days. The strategy also said that when prisoners had a disciplinary hearing and was suspected of PS use, they should be referred to the substance misuse team. It also said that when healthcare staff attend a suspected PS incident, they should refer the prisoner to the substance misuse team to be seen within 48 hours. This did not happen for Mr England.

66. At the time of Mr England's death, the substance misuse strategy was being reviewed and was reissued in August 2018, three months after Mr England's death. The revised strategy added more robust processes such as a protocol to manage prisoners suspected of using PS and a requirement for mandatory drug testing, including where prisoners were suspected of using PS.

67. We acknowledge that Wymott has a drug strategy in place and that staff are working hard to implement it. Nevertheless, the number of prisoners on E wing found to be under the suspected influence of PS at the time of Mr England's death, indicated that prisoners were able to access drugs easily. It is clear that more needs to be done to reduce the supply and the demand for illicit substances, including PS.

68. Wymott is not alone in facing this problem – it is a serious problem across much of the prison estate. Individual prisons are for the most part doing their best to tackle the problem by developing their own local drug strategies. However, in the PPO's view, there is now an urgent need for HMPPS to provide evidence-based advice to prisons on what works. In a number of recent investigations, we recommended that the Chief Executive of HMPPS should issue detailed national guidance on measures to reduce the supply and demand of drugs, including PS, in prisons. We also wrote to the Prisons Minister last year to raise our concerns about the high number of drug-related deaths we were investigating. In response, the Chief Executive told us that HMPPS planned to issue a national drug strategy in the autumn of 2018. We are concerned that at the time of writing (January 2019), this strategy has still not been issued. We therefore make the following recommendation:

The Chief Executive of HMPPS should provide the Ombudsman with a revised date for issuing detailed national guidance on measures to reduce the supply and demand of drugs in prisons, and an assurance that this new date will be met.

Substance misuse

69. Mr England had a history of substance misuse and staff suspected that he was under the influence of PS a number of times. After each episode, they monitored him and downgraded him under the incentives scheme for either seven or 28 days, but did not follow the other prescribed steps.

70. The security assessment of Mr England's behaviour assessed him as a runner in the supply and distribution of drugs in Wymott, and that he received illicit substance in payment. He was viewed as a casual user of drugs. However, despite concerns from December 2017 that he was involved in the illicit drug culture as a user and runner, no one referred him to the prison's substance misuse team until February 2018.

71. We are concerned that PS were readily available to Mr England. It appears that Mr England obtained drugs without difficulty on E wing and even in the CSU. Despite frequent punishments, Mr England continued to take illicit drugs. Staff often described his behaviour as erratic. We consider that prison staff could have done more in response to intelligence that Mr England was involved in the illicit drugs market, particularly as there is no evidence that staff considered measures to restrict his access to illicit drugs. We are concerned that staff do not appear to have arranged for him to have a mandatory drugs test or considered undertaking a prescribed medication spot check, as suggested in Wymott's drug strategy. The clinical reviewer noted that there were missed opportunities to refer Mr England to psychosocial drug services and to complete joint risk assessments. We make the following recommendation:

The Governor should ensure that prisoners suspected of using psychoactive substances, or other illicit substances, are managed in line with the local drug strategy.

Emergency response

72. Records show that prison staff went into Mr England's cell and raised the alarm on 19 May promptly. In response, healthcare staff reached the cell quickly and there was a good effort to resuscitate Mr England. However, there was a problem with one of the defibrillators as a pad was missing which meant that staff had to locate another machine. This did not have any impact as a second defibrillator was quickly found. However, it is important that emergency equipment is in working order. The Head of Healthcare told the investigator that the defibrillators on the wings belonged to the prison and were not the healthcare team's equipment although they completed weekly checks on them. We therefore recommend that:

The Governor and Head of Healthcare should ensure that all emergency response equipment is in good working order, including that staff regularly check defibrillators and replace any missing pads promptly.

Debriefing and staff support

73. Prison Service Instruction (PSI) 64/2011 requires that a "hot debrief" is held immediately after a death in custody, and is led by a senior member of staff. The purpose of the hot debrief, as set out in PSI 08/2010 on post-incident care, is to ensure that the immediate needs of the staff involved are met. It was good to see that prison staff felt supported after the incident but disappointing that healthcare staff did not. The clinical reviewer said that the Head of Healthcare should provide the opportunity for healthcare staff to attend a healthcare-specific debriefing session and be invited to contribute to the 72-hour post-incident report, as well as be offered group or individual support. We agree and therefore recommend:

The Head of Healthcare should ensure that healthcare staff are appropriately supported after the death of a prisoner, in line with national instructions.

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